ALABAMA MEDICAID AGENCY

FAMILY PLANNING HOME VISIT

PATIENT NAME: _____ AGE: _____

MEDICAID NUMBER: _____

ADDRESS: _____

DATE OF SERVICE: _____ TYPE OF SERVICE: _____

FAMILY PLANNING CONSENT

I, _____, voluntarily request and consent to receive family planning services from _____. I understand that a brief history, including family, personal, medical, and contraceptive information will be obtained prior to the provision of home visit services and selection of a birth control method. I understand that I should receive a follow-up visit within six weeks for regular family planning services at the provider's office/clinic.

_____
Patient Signature Date

The patient has voluntarily given consent for family planning services. No coercion or mental pressure was applied in obtaining the patient's signature.

_____
Witness Signature Date

_____
Title

FAMILY HISTORY

(Code Member Having Disease)
(C: F--Father, M--Mother, S--Sibling, GP--Grandparent, O--Other)

Heart disease	_____	Diabetes	_____	Blood problem/disease	_____	Tuberculosis	_____	Foster care	_____
Stroke	_____	Cancer	_____	Nerve/mental problem	_____	Birth defects	_____	Other	_____
Asthma	_____	High BP	_____	Alcohol/drug abuse	_____	Mental Retardation	_____		

MEDICAL/SURGICAL/OB-GYN HISTORY

(Code: 0=Negative, +=Positive - Detail positive answers)

Diabetes_____	Epilepsy_____	Tobacco Use_____	Mental_____	Abortions_____
Hypertension_____	Hepatitis_____	Phlebitis_____	GYN Surgery_____	Stillbirths_____
Heart Disease_____	TB_____	Asthma_____	Gravida_____	Medications_____
Kidney Disease_____	Thyroid_____	Allergies_____	Para_____	

Major Operations:Year/Type_____

Remarks:_____

_____

MENSTRUAL/CONTRACEPTIVE HISTORY:

Previous Contraceptive Method: _____
Problems with method: _____
Date of Delivery: _____
LMP: _____
Menses: _____
Contraindications: _____
BP: _____ WT: _____

NOTE: ONE OF THE TWO COUNSELING SECTIONS BELOW *MUST* BE COMPLETED

Family Planning Counseling Using PT + 3 Teaching Method (Initial Here): _____

OR

Alternative Family Planning Counseling (Initial Each Blank Below As Completed):
Reproductive anatomy/physiology _____
Contraceptive methods & effectiveness _____
Side effects/dangers _____
How to use chosen method _____
Contraceptive literature (Fact sheet) given _____
Phone number to call for problem/emergency _____

NEXT APPOINTMENT: _____ _____
Date Time

Supplies issued: _____ **Prescription:** _____

SUMMARY:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____
SIGNATURE DATE

_____
TITLE